FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0046458

Facility Name: EXCEPTIONAL HEALTH CENTER

Address: 5701 WEST 79TH STREET (Number) BURBANK (City) 60459 (Zip Code)

County: COOK

Telephone Number: 708-499-5400 **Fax #** 708-499-5472

IDPA ID Number: 52-1979253-001

Date of Initial License for Current Owners: 12/29/03

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: TRISH KELLY **Telephone Number:** 410-773-5681

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) SEAN NOLAN

(Title) SENIOR V.P.

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number EXCEPTIONAL HEALTH CENTER # 0046458 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 55

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	55	Skilled (SNF)	55	20,075	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	55	TOTALS	55	20,075	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,964	1,077	3,911	17,952	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,964	1,077	3,911	17,952	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.42%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/29/03

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/29/03 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 55 and days of care provided 3,136

Medicare Intermediary HIGHMARK MEDICARE SERVICES

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number EXCEPTIONAL HEALTH CENTER # 0046458 **Report Period Beginning:** 1/1/2005 **Ending:** 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	120,732	7,634	11,634	140,000		140,000		140,000			1
2	Food Purchase		90,369		90,369		90,369		90,369			2
3	Housekeeping	73,303	17,506		90,809		90,809		90,809			3
4	Laundry	16,958	10,235	2,003	29,196		29,196		29,196			4
5	Heat and Other Utilities			110,032	110,032		110,032	71	110,103			5
6	Maintenance	17,167	4,404	57,129	78,700		78,700	1,502	80,202			6
7	Other (specify):*			18,477	18,477		18,477		18,477			7
8	**TOTAL General Services**	228,160	130,148	199,275	557,583		557,583	1,573	559,156			8
	B. Health Care and Programs											
9	Medical Director			75,750	75,750		75,750		75,750			9
10	Nursing and Medical Records	1,409,070	217,334	146,807	1,773,211	(78,834)	1,694,377	33,480	1,727,857			10
10a	Therapy	306,476	60,370	381,106	747,952	(405,222)	342,730		342,730			10a
11	Activities	29,955	1,025	2,456	33,436		33,436		33,436			11
12	Social Services	35,064		1,469	36,533		36,533		36,533			12
13	CNA Training											13
14	Program Transportation			117	117		117		117			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,780,565	278,729	607,705	2,666,999	(484,056)	2,182,943	33,480	2,216,423			16
	C. General Administration											
17	Administrative	76,359		215,093	291,452		291,452	(104,527)	186,925			17
18	Directors Fees											18
19	Professional Services			24,131	24,131		24,131	18,189	42,320			19
20	Dues, Fees, Subscriptions & Promotions			24,686	24,686		24,686	2,910	27,596			20
21	Clerical & General Office Expenses	64,467	30,507	272,599	367,573		367,573	(85,373)	282,200			21
22	Employee Benefits & Payroll Taxes			460,430	460,430		460,430	(4,186)	456,244			22
23	Inservice Training & Education			984	984		984	(10)	974			23
24	Travel and Seminar			2,401	2,401		2,401	6,077	8,478			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			74,955	74,955		74,955	(42,856)	32,099			26
27	Other (specify):*			942	942		942	(942)				27
28	**TOTAL General Administration**	140,826	30,507	1,076,221	1,247,554		1,247,554	(210,718)	1,036,836			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,149,551	439,384	1,883,201	4,472,136	(484,056)	3,988,080	(175,665)	3,812,415			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number EXCEPTIONAL HEALTH CENTER #0046458 **Report Period Beginning:** 1/1/2005 **Ending:** 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			2,813	2,813		2,813		2,813			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							21,912	21,912			32
33	Real Estate Taxes			120,961	120,961		120,961	(2,078)	118,883			33
34	Rent-Facility & Grounds			252,187	252,187		252,187		252,187			34
35	Rent-Equipment & Vehicles			6,752	6,752		6,752	2,635	9,387			35
36	Other (specify):*							18,900	18,900			36
37	**TOTAL Ownership**			382,713	382,713		382,713	41,369	424,082			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		237,782	128,467	366,249	484,056	850,305		850,305			39
40	Barber and Beauty Shops			2,891	2,891		2,891		2,891			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			32,085	32,085		32,085		32,085			42
43	Other (specify):* **Rounding**		(1)	(1)	(2)		(2)		(2)			43
44	**TOTAL Special Cost Centers**		237,781	163,442	401,223	484,056	885,279		885,279			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,149,551	677,165	2,429,356	5,256,072		5,256,072	(134,296)	5,121,776			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number EXCEPTIONAL HEALTH CENTER # 0046458 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(578)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(364)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(229,114)	21		24
25	Fund Raising, Advertising and Promotional	(2,631)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(53,499)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (286,186)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	109,452	17	34
35	Other- Attach Schedule	(67,014)	Various	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 42,438		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (243,748)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		10,198	10	42
43	Prescription Drugs		X			43
44	Exceptional Care Program	X		65,009	10	44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$ 75,207		47

STATE OF ILLINOIS

EXCEPTIONAL HEALTH CENTER

ID# 0046458

Report Period Beginning: 1/1/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2	REMOVE LEGAL FEES	(8,220)	19	2
3	REMOVE ACCOUNTING FEES	(3,165)	19	3
4	REMOVE SOFTWARE EXPENSE	(7,039)	21	4
5	REMOVE DATA COMMUNICATIONS	(10,497)	21	5
6	REMOVE OVERNIGHT FEES	(1,059)	21	6
7	REMOVE BANK FEES	(6,991)	21	7
8				8
9	REMOVE COMMUNITY REL. (DEPT 530)	(250)	20	9
10	REMOVE COMMUNITY REL. (DEPT 515)	(250)	20	10
11	REMOVE COMMUNITY REL. (DEPT 515)	(12,627)	21	11
12	REMOVE ADMISSIONS EXPENSE	(869)	10	12
13				13
14	EMPLOYEE PATIENT LOSS FUND	(96)	21	14
15				15
16	AIRLINE TRAVEL	(658)	24	16
17				17
18	REMOVE COMMUNITY REL. (DEPT 515)	(10)	23	18
19	REMOVE COMMUNITY REL. (DEPT 515)	(599)	24	19
20				20
21	REMOVE RESIDENT GIFTS	(277)	20	21
22				22
23	REMOVE HEALTHCARE ASSN. LOBBYING	(892)	20	23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(53,499)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number EXCEPTIONAL HEALTH CENTER **#** 0046458 **Report Period Beginning:** 1/1/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	71	0	0	0	0	0	0	0	0	0	71	5
6	Maintenance	0	1,502	0	0	0	0	0	0	0	0	0	1,502	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	1,573	0	0	0	0	0	0	0	0	0	1,573	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(869)	34,349	0	0	0	0	0	0	0	0	0	33,480	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(869)	34,349	0	0	0	0	0	0	0	0	0	33,480	16
	C. General Administration													
17	Administrative	109,452	(213,979)	0	0	0	0	0	0	0	0	0	(104,527)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(11,385)	29,574	0	0	0	0	0	0	0	0	0	18,189	19
20	Fees, Subscriptions & Promotions	(4,300)	7,210	0	0	0	0	0	0	0	0	0	2,910	20
21	Clerical & General Office Expenses	(267,423)	182,050	0	0	0	0	0	0	0	0	0	(85,373)	21
22	Employee Benefits & Payroll Taxes	(22,080)	17,894	0	0	0	0	0	0	0	0	0	(4,186)	22
23	Inservice Training & Education	(10)	0	0	0	0	0	0	0	0	0	0	(10)	23
24	Travel and Seminar	(1,257)	7,334	0	0	0	0	0	0	0	0	0	6,077	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(42,856)	0	0	0	0	0	0	0	0	0	0	(42,856)	26
27	Other (specify):*	(942)	0	0	0	0	0	0	0	0	0	0	(942)	27
28	**TOTAL General Administration**	(240,801)	30,083	0	0	0	0	0	0	0	0	0	(210,718)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(241,670)	66,005	0	0	0	0	0	0	0	0	0	(175,665)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number EXCEPTIONAL HEALTH CENTER **#** 0046458 **Report Period Beginning:** 1/1/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	21,912	0	0	0	0	0	0	0	0	0	21,912	32
33	Real Estate Taxes	(2,078)	0	0	0	0	0	0	0	0	0	0	(2,078)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	2,635	0	0	0	0	0	0	0	0	0	2,635	35
36	Other (specify):*	0	18,900	0	0	0	0	0	0	0	0	0	18,900	36
37	**TOTAL Ownership**	(2,078)	43,447	0	0	0	0	0	0	0	0	0	41,369	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(243,748)	109,452	0	0	0	0	0	0	0	0	0	(134,296)	45

Facility Name & ID Number EXCEPTIONAL HEALTH CENTER # 0046458 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
THI HOLDINGS, LLC	100					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	HEAT & OTHER UTILITIES	$	THI HOLDINGS, LLC	100.00%	$ 71	$ 71	1
2	V	6	MAINTENANCE		THI HOLDINGS, LLC		1,502	1,502	2
3	V	10	CLINICAL		THI HOLDINGS, LLC		34,349	34,349	3
4	V	17	ADMINISTRATIVE	215,093	THI HOLDINGS, LLC		1,114	(213,979)	4
5	V	19	PROFESSIONAL SERVICES		THI HOLDINGS, LLC		29,574	29,574	5
6	V	20	DUES, FEES, SUBSCRIPTIONS		THI HOLDINGS, LLC		7,210	7,210	6
7	V	21	CLERICAL & GENERAL		THI HOLDINGS, LLC		182,050	182,050	7
8	V	22	EMPLOYEE BENEFITS		THI HOLDINGS, LLC		17,894	17,894	8
9	V	24	TRAVEL AND SEMINAR		THI HOLDINGS, LLC		7,334	7,334	9
10	V	32	INTEREST		THI HOLDINGS, LLC		21,912	21,912	10
11	V	35	RENT-EQUIPMENT & VEHICLES		THI HOLDINGS, LLC		2,635	2,635	11
12	V	36	OTHER HOME OFFICE CAPITAL		THI HOLDINGS, LLC		18,900	18,900	12
13	V								13
14	Total			$ 215,093			$ 324,545	$ * 109,452	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number EXCEPTIONAL HEALTH CENTER # 0046458 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number EXCEPTIONAL HEALTH CENTER # 0046458 Report Period Beginning: 1/1/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: THI HOLDINGS, LLC
Street Address: 910 RIDGEBROOK ROAD BLDG 300
City / State / Zip Code: SPARKS, MD 21152
Phone Number: (410) 773-1000
Fax Number: (410) 773-5829

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2		DIRECT TRACKING OF EXPENSES AND ALLOCATIONS OF POOLED COSTS BASED ON PERCENT OF TOTAL COSTS								2
3		SEE HOME OFFICE COST REPORT								3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number EXCEPTIONAL HEALTH CENTER # 0046458 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	CAPITAL SOURCE		X		VARIES	9/2003	75,000,000	4,742,704		10.5000	21,912	6
7												7
8												8
9	TOTAL Facility Related						$ 75,000,000	$ 4,742,704			$ 21,912	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 75,000,000	$ 4,742,704			$ 21,912	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number EXCEPTIONAL HEALTH CENTER **#** 0046458 **Report Period Beginning:** 1/1/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	121,745	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	120,314	2
3. Under or (over) accrual (line 2 minus line 1).	$	(1,431)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	120,314	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	118,883	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	84,590	8
	2001	94,948	9
	2002	110,828	10
	2003	116,162	11
	2004	120,314	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$		13
14	PLUS APPEAL COST FROM LINE 5	$		14
15	LESS REFUND FROM LINE 6	$		15
16	AMOUNT TO USE FOR RATE CALCULATION	$		16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME EXCEPTIONAL HEALTH CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0046458

CONTACT PERSON REGARDING THIS REPORT TRISH KELLY

TELEPHONE 410-773-5681 FAX #: 410-773-5829

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	19-32-205-023-0000	LONG TERM CARE FACILITY	$ 113,746.78	$ 113,746.78
2.	19-32-204-006-0000	LONG TERM CARE FACILITY	$ 6,566.89	$ 6,566.89
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 120,313.67	$ 120,313.67

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number EXCEPTIONAL HEALTH CENTER # 0046458 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 13,728 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number EXCEPTIONAL HEALTH CENTER # 0046458 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	BURNER RACK REPAIR			2004	819	55	15	55		105	9
10	WIRING FOR SWITCHES			2004	4,800	276	17	276		505	10
11	INSTALL BACKFLOW ON SPRINKLER			2004	4,500	258	17	258		474	11
12	HYDROGUARD MIXING VALVE - WATER			2004	1,468	85	17	85		142	12
13	AIR CONDITIONER			2004	510	102	5	102		145	13
14	TEMP CONTROLLER FOR COOLER			2004	1,121	112	10	112		178	14
15	DRAIN LINE RE-PIPED IN WALL			2004	1,375	82	17	82		96	15
16	REPLACE WATER HEATER			2004	939	94	10	94		110	16
17	WALK-IN FREEZER REPAIR			2005	924	56	15	56		56	17
18	COOLER - REPLACE GASKET, SENSOR			2005	574	32	15	32		32	18
19	REPAIR GENERATOR CONTROLS			2005	1,028	71	12	71		71	19
20	WALK-IN FREEZER REPAIR			2005	722	48	15	48		72	20
21	REPAIR WATER HEATER			2005	763	19	10	19		19	21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number EXCEPTIONAL HEALTH CENTER # 0046458 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 19,543	$ 1,291		$ 1,291	$	$ 2,004	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number EXCEPTIONAL HEALTH CENTER # 0046458 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 7,553	$ 648	$ 648	$		$ 750	71
72	Current Year Purchases	24,449	874	874			874	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 32,003	$ 1,523	$ 1,523	$		$ 1,625	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 51,545	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 2,813	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 2,813	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,628	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number EXCEPTIONAL HEALTH CENTER # 0046458 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: AMERICAN NATIONAL BANK AND TRUST COMPANY OF CHICAGO
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		55	12/29/03	$ 255,564	10	15	3
4	Additions							4
5								5
6								6
7	TOTAL		55		$ 255,564 **			7

8. List separately any amortization of lease expense included on page 4, line 34. (3,377)
   This amount was calculated by dividing the total amount to be amortized 9,380
   by the length of the lease 4 .
9. Option to Buy: [X] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning 12/29/2003
    Ending 12/31/2006

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2006	$ 255,564 * (1+CPI)
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 6,752 Description: (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number EXCEPTIONAL HEALTH CENTER # 0046458 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number EXCEPTIONAL HEALTH CENTER # 0046458 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a.3	hrs	$	5,241	$ 74,472	$ 936	5,241	$ 75,408	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		1,174	21,386	1,461	1,174	22,847	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		4,037	68,039	475	4,037	68,514	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2 / 10-2	# of prescrpts			12,500	248,593		261,093	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	X-Ray/Lab/Equip Other (specify):	39		7,588		6,987	100,778		115,353	13
14	TOTAL			$ 7,588	10,452	$ 183,384	$ 352,243	10,452	$ 543,216	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number EXCEPTIONAL HEALTH CENTER **#** 0046458 **Report Period Beginning:** 1/1/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 95,612	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,654,140		3
4	Supply Inventory (priced at)	15,213		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,995		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,769,960	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	51,545		16
17	Accumulated Depreciation (book methods)	(3,628)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 47,917	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,817,876	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 36,509	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	76,208		30
31	Accrued Taxes Payable (excluding real estate taxes)	70,743		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	401(K) w/h, 401(K) loan	502		36
37	repay, savings bond w/h			37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 183,962	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany	3,137,351		43
44	FAS straight line rent	6,003		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,143,354	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,327,316	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,509,440)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,817,876	$	48

***(See instructions.)**

Facility Name & ID Number EXCEPTIONAL HEALTH CENTER # 0046458 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (550,312)	1	
2	Restatements (describe):		2	
3	PRIOR YEAR ADJUSTMENTS	4,307	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (546,005)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(954,221)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe) Construction in Progress	(9,214)	15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (963,435)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,509,440)	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number EXCEPTIONAL HEALTH CENTER # 0046458 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,981,655	1
2	Discounts and Allowances for all Levels	(5,207,552)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ (1,225,897)	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,272,647	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 5,272,647	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	173,489	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	63,606	19
20	Radiology and X-Ray	2,300	20
21	Other Medical Services	1,646	21
22	Laundry	14,056	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 255,097	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Interest income	3	28
28a	ROUNDING	1	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,301,851	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	557,583	31
32	Health Care	2,666,999	32
33	General Administration	1,247,554	33
	B. Capital Expense		
34	Ownership	382,713	34
	C. Ancillary Expense		
35	Special Cost Centers	401,223	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,256,072	40
41	**Income before Income Taxes (line 30 minus line 40)****	(954,221)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (954,221)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number EXCEPTIONAL HEALTH CENTER # 0046458 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,012	2,146	$ 74,926	$ 34.91	1
2	Assistant Director of Nursing	1,801	2,071	60,548	29.24	2
3	Registered Nurses	19,615	21,306	568,768	26.70	3
4	Licensed Practical Nurses	5,662	7,135	127,924	17.93	4
5	CNAs & Orderlies	42,227	43,862	512,501	11.68	5
6	CNA Trainees					6
7	Licensed Therapist	14,056	14,592	324,240	22.22	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,953	3,055	29,955	9.81	10
11	Social Service Workers	1,954	2,082	35,064	16.84	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	6,222	6,834	89,993	13.17	14
15	Cook Helpers/Assistants	3,579	3,872	30,739	7.94	15
16	Dishwashers					16
17	Maintenance Workers	1,293	1,397	17,167	12.29	17
18	Housekeepers	8,170	8,758	73,303	8.37	18
19	Laundry	1,892	2,036	16,958	8.33	19
20	Administrator	2,027	2,094	76,359	36.47	20
21	Assistant Administrator					21
22	Other Administrative	2,628	2,739	23,833	8.70	22
23	Office Manager	1,921	2,107	32,096	15.23	23
24	Clerical	589	845	8,538	10.10	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,861	2,053	24,669	12.02	31
32	Other Health Care(specify)					32
33	Other(specify) Central Supply	1,964	2,129	21,970	10.32	33
34	TOTAL (lines 1 - 33)	122,426	131,113	$ 2,149,551 *	$ 16.39	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	As Needed	$ 11,634	1-3	35
36	Medical Director	Monthly	75,750	9-3	36
37	Medical Records Consultant	Monthly	4,865	10-3	37
38	Nurse Consultant	As Needed	250	10-3	38
39	Pharmacist Consultant	Monthly	1,816	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	As Needed	578	11-3	44
45	Social Service Consultant	As Needed	1,469	12-3	45
46	Other(specify)				46
47	Administrative Contract Services	As Needed	2,306	19-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 98,668		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,379	$ 75,774	10-3	50
51	Licensed Practical Nurses	1,619	59,037	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,998	$ 134,811		53

Facility Name & ID Number EXCEPTIONAL HEALTH CENTER # 0046458 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kristin Mitchell	ADMINISTRATOR	0	$ 76,359
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 76,359

B. Administrative - Other

Description	Amount
Central Office Costs	$ 215,093
TOTAL (agree to Schedule V, line 17, col. 3)	$ 215,093
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
COMPLEX PROPERTY ADVISOR	CPS	$ 200
FILE CENTER	CPS	973
MARTIN WHALEN OFFICE SOL.	CPS	1,133
NAT'L REGISTERED AGENTS	LEGAL	190
STATE OF ILLINOIS	LEGAL	300
ROYAL OAKS CORP	LEGAL	118
ACHIEVE HEALTHCARE TECH	SOFTWARE SUPPORT	8,253
DATA CONTROL TECH.	SOFTWARE SUPPORT	495
LYNNE ONUFER	SOFTWARE SUPPORT	614
ADT SECURITY SERVICES	SECURITY	300
WASHBURN MACHINERY	SERVICE CONTRACTS	170
CORP. ALLOCATIONS	LEGAL/ACCTG FEES	11,385
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 24,131

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 74,859
Unemployment Compensation Insurance	29,367
FICA Taxes	156,968
Employee Health Insurance	159,762
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
MISCELLANEOUS OTHER BENEFITS	17,394
HOME OFFICE - BENEFITS	17,894
TOTAL (agree to Schedule V, line 22, col.8)	$ 456,244

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,069
Advertising: Employee Recruitment	16,438
Health Care Worker Background Check	
(Indicate # of checks performed)	
ADVERTISING & PR	2,631
COMMUNITY RELATIONS	500
DUES AND SUBSCRIPTIONS	1,879
HOME OFFICE DUES	7,210
Less: Public Relations Expense	(500)
Non-allowable advertising	(2,631)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,596

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
SEE ATTACHED SCHEDULE	1,144
HOME OFFICE	7,334
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,478

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number EXCEPTIONAL HEALTH CENTER # 0046458 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number EXCEPTIONAL HEALTH CENTER **#** 0046458 **Report Period Beginning:** 1/1/2005 **Ending:** 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILLINOIS HEALTH CARE - $2,706**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **11**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **31,269** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? **X** YES NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **32,085**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **NO** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **N/A** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **KPMG** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NO** If no, please explain. **AUDIT IS INCOMPLETE**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.